

**UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS**

IN RE: PHARMACEUTICAL INDUSTRY
AVERAGE WHOLESALE PRICE
LITIGATION

MDL No. 1456

Master File No. 01-CV-12257-PBS

THIS DOCUMENT RELATES TO:
ALL ACTIONS

Judge Patti B. Saris

**AFFIDAVIT OF THOMAS TRUSKY ON BEHALF OF ESTATE OF THERESA
TRUSKY**

I, Thomas Trusky, pursuant to 28 U.S.C. §1746, on oath, depose and state as follows:

1. I am a resident of Forest City, Pennsylvania. I have personal knowledge of the facts stated below.
2. I submit this affidavit in further support of my application to be appointed as a Class Representative for Class 1 of the settlement with the Track 2 defendants.
3. Since my initial contact with Marc H. Edelson, Esq. in the winter of 2009, I have been in continual contact with him in order to be kept apprised of the status of the litigation. I have also inquired as to the status of the settlements with BMS and AZ.
4. While I agreed to become a Class Representative 1 after the Track 2 settlement had been negotiated, I am aware of the terms and believe the allocation is fair. I have been updated as to the status of the approval of the settlement and understand that Class Counsel are doing everything they can to achieve the best results for the various classes of claimants.

5. This case is very important to me. We have spent a considerable sum of money over the years on medications covered by the various settlements and would like to hold the defendants responsible for any overcharges we have paid.

6. As the attached copy of Theresa's claim form demonstrates, Theresa was provided numerous times with drugs that are covered by the Track 2 settlement. While I was able to locate some proof of payment for drugs administered in 2004, I have been only able to find one credit card bill documenting payments made in 2003. The copy of the invoice is attached. I have looked diligently for additional supporting documents and have made numerous telephone inquiries.

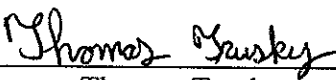
7. My understanding is that the information I seek is either no longer available or is in storage and would be very difficult to locate in a timely fashion.

8. In addition, during 2003, Theresa paid for much of her medical care with her own credit cards and by her own checks. I cannot locate any of this information for the reasons stated earlier.

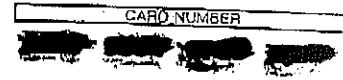
9. Since our supplemental insurance only provided coverage after we paid for the first Four Thousand Dollars (\$4000.00) in medical care, I am certain that many of the medications listed in 2003 were paid for us out of pocket.

I declare under penalty of perjury that the foregoing is true and correct.

Date: June 23, 2011


Thomas Trusky

AMERICHoice F C U
20 SPORTING GREEN
MECHANICSBURG PA 17050-2392



PLEASE SUBMIT ADDRESS CHANGES ON THE DETACHABLE ENVELOPE FLAP ONLY.

AMOUNT OF PAYMENT ENCLOSED

CLOSING DATE
06/13/03

NEW BALANCE
[REDACTED]

MINIMUM PAYMENT
** [REDACTED] **

PAYMENT DATE
07/08/03

\$ [REDACTED]

THOMAS R TRUSKY
332 SUSQUEHANNA ST
FOREST CITY PA 18421-1308

MAKE CHECK PAYABLE TO:

AMERICHoice F.C.U
PO BOX 67001
HARRISBURG, PA 17106-7001

[REDACTED]

FAX # 215-230-8735

01 [REDACTED] 00000000 00074503 3

PLEASE RETURN THIS PORTION TO ENSURE PROPER CREDIT

DO NOT STAPLE CHECK

CLOSING DATE
06/13/03

CARD NUMBER
[REDACTED]

CREDIT
LIMIT
[REDACTED]

AVAILABLE
CREDIT
[REDACTED]

SEND INQUIRIES TO:

AMERICHoice F C U
PO BOX 60070
HARRISBURG PA 17106
(800) 433 0505 NATL 800
(717) 697 3474 CARD COORD

| REFERENCE NUMBER | MCC CODE | POSTING DATE | TRANS DATE | DESCRIPTION | AMOUNT |
|-------------------------|----------|--------------|------------|---------------------------|--------|
| 24226383135360531585325 | 5411 | 5 16 | 5 15 | WM SUPERCENTER | 41.29 |
| 24445003136604264438535 | 5411 | 5 18 | 5 15 | DICKSON CITY PA | 38.75 |
| 24610433136010180294507 | 5200 | 5 18 | 5 15 | WEGMANS #076 SE1 | 38.97 |
| 24435653136236000018976 | 8062 | 5 18 | 5 16 | SCRANTON PA | 75.13 |
| 24435653137364905682602 | 5964 | 5 18 | 5 16 | THE HOME DEPOT 4118 | 75.13 |
| 24435653141286624282014 | 8011 | 5 22 | 5 20 | DICKSON CITY PA | 25.31 |
| 24445003142607092164225 | 5411 | 5 23 | 5 21 | MARIAN COMMUNITY HOSP | 14.71 |
| 24164053142378000067876 | 5542 | 5 23 | 5 21 | CARBONDALE PA | 20.00 |
| 24435653142236000016477 | 8062 | 5 23 | 5 22 | MEDCO HEALTH FT WORTH | 87.66 |
| 24158383145607907670770 | 8099 | 5 25 | 5 23 | 800-888-7010 TX | 36.72 |
| 24158383145607907670853 | 8099 | 5 25 | 5 23 | PHYSICIANS HEALTH OBGYN | 36.71 |
| 24445003149610436472315 | 5411 | 5 30 | 5 28 | SCRANTON PA | 30.48 |
| 24164053149837000004042 | 5541 | 5 30 | 5 28 | WEGMANS #076 SE1 | 21.00 |
| 24445003154612874577359 | 5411 | 6 04 | 6 02 | SCRANTON PA | 49.99 |
| 24164053154837000004838 | 5541 | 6 04 | 6 02 | EXXONMOBIL 09642893 | 21.00 |
| 24435653155236000017834 | 8062 | 6 05 | 6 04 | MAYFIELD PA | 30.55 |
| 24717053156641561122157 | 7399 | 6 05 | 6 04 | MARIAN COMMUNITY HOSP | 89.40 |
| | | | | CARBONDALE PA | |
| | | | | N-E PENNSYLVANIA TELEPHON | |
| | | | | FOREST CITY PA | |

AVERAGE DAILY BALANCE
SUBJECT TO FINANCE CHARGE*

PERIODIC
RATE

CORRESP
APR

FINANCE
CHARGE

ANNUAL
PERCENTAGE RATE

ACCOUNT
SUMMARY

MY TOTAL OUT OF POCKET EXPENSE FOR
TERESA WAS 2,051.93 BY CHECK AND
CREDIT CARD. TO REACH THE 4,000.00
PLATEAU WE HAD TO INCUR ADDITIONAL

medical expense of 1,948.07 for Empire
Blue Cross to then pay for all medical expense
through medicare which they did. I have no record
of her credit card statements or checking to verify the additional
1,948.

COPIES OF
Two checks
TOTALING \$209.20
I AM ATTEMPTING
TO GET FROM MY
CREDIT UNION.
THAT WERE PAID
TO MARIAN COMM. HOSPITAL
FOR TERESA'S CARE.

**MUST BE POSTMARKED
BY JULY 1, 2011**

AWP TRACK 2 SETTLEMENT
MEDICARE PART B CLAIM FORM

IF YOU DO NOT MAKE ANY CHANGES
TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.

FOR OFFICIAL USE ONLY

12

Section A: Patient Information

Please review the preprinted information below and fill in any missing information. If you need to make corrections, please make them in the space provided.



THERESA TRUSKY
335 SUSQUEHANNA ST
FOREST CITY PA 18421

☐ If the preprinted address to the left is incorrect or out of date, OR if there is no preprinted data to the left, check this box and print the patient's current name and address

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

(_____) _____ - _____
Daytime Telephone Number

Please review the information printed on this claim form carefully.

- If you make any changes: You must sign and return this claim form.
- If you do not make any changes: Do not return this claim form. A check will be automatically mailed to you.

Section B: Patient Representative Information

If you are the patient, **DO NOT** complete this section. Complete this section only if you are a representative (such as a spouse, guardian, executor or personal representative) filing this claim on behalf of the patient listed above.

Representative's Name: _____ Relationship to Patient: _____

Representative's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Telephone Number: (_____) _____ - _____

Evening Telephone Number: (_____) _____ - _____

IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.



**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. **If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.**

| Medicare Part B Purchase Information Chart | | | |
|--|---|--------------------|---------------------------|
| | COLUMN A | COLUMN B | COLUMN C |
| | Name of Drug | Date Drug Received | Amount Paid Out-of-Pocket |
| 1 | ADENOSINE | 10/29/2003 | \$44.64 |
| 2 | DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE | 12/5/2003 | \$366.26 |
| 3 | EPOGEN | 12/1/2003 0:00 | 72.80 |
| 4 | EPOGEN | 12/26/2003 | 72.80 |
| 5 | EPOGEN | 8/4/2003 | 72.80 |
| 6 | EPOGEN | 8/11/2003 | 72.80 |
| 7 | NEULASTA | 9/9/2003 | \$69.82 |
| 8 | NEULASTA | 9/30/2003 | \$69.82 |
| 9 | EPOGEN | 10/20/2003 | 72.80 |
| 10 | EPOGEN | 10/27/2003 | 72.80 |
| 11 | NEULASTA | 10/21/2003 | \$418.92 |
| 12 | EPOGEN | 7/7/2003 | 72.80 |
| 13 | NEULASTA | 7/15/2003 | \$69.82 |
| 14 | EPOGEN | 9/8/2003 | 72.80 |
| 15 | NEULASTA | 2/2/2004 | 519.20 |
| 16 | NEULASTA | 2/23/2004 | 519.20 |
| 17 | DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE | 2/20/2004 | \$583.18 |
| 18 | EPOGEN | 2/12/2004 | \$94.08 |
| 19 | EPOGEN | 10/13/2003 | 72.80 |
| 20 | NEUPOGEN | 7/1/2004 | \$68.88 |

**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

PLEASE CONTINUE TO THE NEXT PAGE



**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. **If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.**

| Medicare Part B Purchase Information Chart | | | |
|--|---|--------------------|---------------------------|
| | COLUMN A | COLUMN B | COLUMN C |
| | Name of Drug | Date Drug Received | Amount Paid Out-of-Pocket |
| 21 | EPOGEN | 7/2/2004 | \$94.08 |
| 22 | EPOGEN | 7/9/2004 | \$94.08 |
| 23 | EPOGEN | 7/30/2004 | \$94.08 |
| 24 | EPOGEN | 4/8/2004 | \$94.08 |
| 25 | EPOGEN | 6/18/2004 | \$94.08 |
| 26 | EPOGEN | 6/25/2004 | \$94.08 |
| 27 | EPOGEN | 8/6/2004 | \$94.08 |
| 28 | EPOGEN | 8/13/2004 | \$94.08 |
| 29 | EPOGEN | 8/20/2004 | \$141.12 |
| 30 | EPOGEN | 8/27/2004 | \$141.12 |
| 31 | EPOGEN | 1/23/2004 | \$94.08 |
| 32 | NEUPOGEN | 6/28/2004 | \$68.88 |
| 33 | NEUPOGEN | 6/29/2004 | \$68.88 |
| 34 | NEUPOGEN | 6/30/2004 | \$68.88 |
| 35 | EPOGEN | 6/4/2004 | \$94.08 |
| 36 | EPOGEN | 6/11/2004 | \$94.08 |
| 37 | EPOGEN | 3/11/2004 | \$94.08 |
| 38 | EPOGEN | 3/19/2004 | \$94.08 |
| 39 | NEULASTA | 1/12/2004 | 519.20 |
| 40 | DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE | 1/9/2004 | \$583.18 |

**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

PLEASE CONTINUE TO THE NEXT PAGE



**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. **If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.**

| Medicare Part B Purchase Information Chart | | | |
|--|---|--------------------|---------------------------|
| | COLUMN A | COLUMN B | COLUMN C |
| | Name of Drug | Date Drug Received | Amount Paid Out-of-Pocket |
| 41 | DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE | 1/30/2004 | \$583.18 |
| 42 | EPOGEN | 1/16/2004 | \$94.08 |
| 43 | SODIUM CHLORIDE | 10/29/2004 | \$0.44 |
| 44 | EPOGEN | 10/29/2004 | \$139.44 |
| 45 | EPOGEN | 10/14/2004 | \$139.44 |
| 46 | NEULASTA | 3/29/2004 | \$19.20 |
| 47 | DOXORUBICIN / DOXORUBICIN HYDROCHLORIDE | 3/26/2004 | \$583.18 |
| 48 | EPOGEN | 3/5/2004 | \$94.08 |
| 49 | EPOGEN | 12/30/2004 | \$139.44 |
| 50 | SODIUM CHLORIDE | 12/30/2004 | \$0.44 |
| 51 | SODIUM CHLORIDE | 10/1/2004 | \$0.44 |
| 52 | EPOGEN | 10/1/2004 | \$139.44 |
| 53 | EPOGEN | 11/30/2004 | \$139.44 |
| 54 | EPOGEN | 12/23/2004 | \$139.44 |
| 55 | SODIUM CHLORIDE | 9/24/2004 | \$0.44 |
| 56 | EPOGEN | 9/24/2004 | \$139.44 |
| 57 | ALCOHOL INJECTION | 12/30/2004 | \$61.56 |
| 58 | DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE | 12/30/2004 | \$0.2 |
| 59 | MANNITOL | 12/30/2004 | \$0.58 |
| 60 | CISPLATIN | 12/30/2004 | \$10.85 |

**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

PLEASE CONTINUE TO THE NEXT PAGE



**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. **If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.**

| Medicare Part B Purchase Information Chart | | | |
|--|---|--------------------|---------------------------|
| | COLUMN A | COLUMN B | COLUMN C |
| | Name of Drug | Date Drug Received | Amount Paid Out-of-Pocket |
| 61 | SODIUM CHLORIDE | 12/10/2004 | \$0.44 |
| 62 | DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE | 11/12/2004 | 0.20 |
| 63 | SODIUM CHLORIDE | 11/12/2004 | \$0.44 |
| 64 | EPOGEN | 11/12/2004 | \$139.44 |
| 65 | SODIUM CHLORIDE | 9/17/2004 | \$0.44 |
| 66 | EPOGEN | 9/17/2004 | \$139.44 |
| 67 | EPOGEN | 10/8/2004 | \$139.44 |
| 68 | ALCOHOL INJECTION | 12/10/2004 | \$61.56 |
| 69 | DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE | 12/10/2004 | 0.20 |
| 70 | MANNITOL | 12/10/2004 | \$0.58 |
| 71 | CISPLATIN | 12/10/2004 | \$10.85 |
| 72 | EPOGEN | 12/10/2004 | \$139.44 |
| 73 | ALCOHOL INJECTION | 12/17/2004 | \$61.56 |
| 74 | DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE | 12/17/2004 | \$0.2 |
| 75 | CISPLATIN | 12/17/2004 | \$10.85 |
| 76 | MANNITOL | 12/17/2004 | \$0.58 |
| 77 | EPOGEN | 12/17/2004 | \$139.44 |
| 78 | SODIUM CHLORIDE | 10/8/2004 | \$0.44 |
| 79 | DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE | 11/19/2004 | 0.20 |
| 80 | SODIUM CHLORIDE | 11/19/2004 | \$0.44 |

**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

PLEASE CONTINUE TO THE NEXT PAGE



44

**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

Section C Continued

Look carefully at the list of covered drugs found on Attachment A of the Notice. Check the chart **above** to make sure it contains all of the covered drugs you were administered or filled a prescription for as a Medicare recipient from January 1, 1991 through January 1, 2005. If it does not, you may add those drugs to the chart **below**.

- Only add drugs if you were responsible for paying a percentage co-payment as a Medicare Part B recipient.
- You are not eligible for a check if a) supplemental insurance covers your entire obligation for co-payment or b) you were responsible for making only flat co-payments.
- Flat co-payments do not vary with the cost of the drug. If your supplemental insurance covered only part of your percentage co-payment obligation, you are still eligible.

In order to add drugs to the chart below:

1. Enter the name of any additional drugs in Column A;
2. Enter dates of administration in Column B;
3. Enter the amount paid in Column C; and
4. Provide one of the following acceptable proofs of a percentage co-payment for each additional covered drug:
 - (1) A receipt, cancelled check, or credit card statement that shows a payment for one of the drugs (other than a flat co-payment); or
 - (2) A letter from a doctor saying that he or she prescribed one of the drugs and you paid part of the cost of one of the drugs (other than a flat co-payment) at least once; or
 - (3) An EOB (explanation of benefits) from your insurer that shows you made or are obligated to make percentage co-payments for the covered drugs; or
 - (4) A notarized statement signed by you indicating you made or are obligated to make a percentage co-payment for the covered drugs from January 1, 1991 through January 1, 2005, including the total of all percentage co-payments for the drugs during the time period; or
 - (5) Records from your pharmacy showing that you made percentage co-payments for the covered drugs purchased from January 1, 1991 through January 1, 2005.

| Additional Medicare Part B Purchase Information Chart | | | |
|---|--------------|------------------------|---------------------------|
| | COLUMN A | COLUMN B | COLUMN C |
| | Name of Drug | Date of Administration | Amount Paid Out-of-Pocket |
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |

-- ATTACH ADDITIONAL PAGES IF NEEDED --



**IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C,
YOU DO NOT NEED TO RETURN THIS CLAIM FORM.**

Section D: Sign and Date Your Claim Form

I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I made a percentage co-payment for one or more of the drugs as indicated in this claim form at some time during the period from January 1, 1991 through January 1, 2005. If not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above.

Signature: _____

Print Name: _____

Date: ____ / ____ / ____

Section E: Mail Your Claim Form

If you did not make any changes to this document, you do not need to return this Claim Form.

Claim Forms that have been changed, along with proof of payment, must be postmarked by **July 1, 2011** and mailed to:

AWP Track 2 Settlement Administrator
P.O. Box 2417
Faribault, MN 55021-9117

If you have any questions, please call 1-877-465-8136 or visit the website at www.AWPTrack2Settlement.com.

REMINDER:

**If you made changes to any information
contained in Sections A, B, or C:**

You must sign and return this claim form.

**If you did not make any changes to the
information printed on the claim form:**

***Do not return this claim form.
A check will be automatically mailed to you.***



CERTIFICATE OF SERVICE BY LEXISNEXIS FILE & SERVE

Docket No. MDL 1456

I, Steve W. Berman, hereby certify that I am one of plaintiffs' attorneys and that, on June 24, 2011, I caused copies of **AFFIDAVIT OF THOMAS TRUSKY ON BEHALF OF ESTATE OF THERESA TRUSKY** to be served on all counsel of record by causing same to be posted electronically via LEXIS-Nexis File & Serve.

/s/ Steve W. Berman

Steve W. Berman